Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-17-0324-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Redacted

Amount in Dispute: $12,916.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for services of August 1, 2016 were denied because preauthorization was required but was not requested…At the post-op appointment on July 25th the claimant was scheduled for additional surgery. The additional procedure was performed a week later on August 1st. While the patient's initial visits, including the initial surgery, were considered as emergency this additional procedure was schedule a week prior to the date of service. Preauthorization should have been requested upon the decision for surgery and schedule on the procedure. There was ample time between the visit and the procedure so that preauthorization could have been requested. The determination that the procedure could wait seven days was, in itself determination that this was not emergency treatment."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2016	26480 Transplant Hand Tendon	$11,046.25	$0.00
	Anesthesia	$750.00	$0.00
	Recovery Room	$1,120.00	$0.00
TOTAL		$12,916.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.2 effective March 30, 2014 defines a medical emergency.
3. 28 Texas Administrative Code §134.600 effective March 30, 2014 requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Precertification/Authorization/Notification absent.
   - X170, 193, W3-Pre-authorization was required, but not requested for this service per DWC rule 134.600.
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.

Issues

Does the disputed outpatient surgery require preauthorization? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon a lack of preauthorization.

The respondent holds that reimbursement is not due because "At the post-op appointment on July 25th the claimant was scheduled for additional surgery. The additional procedure was performed a week later on August 1st. While the patient's initial visits, including the initial surgery, were considered as emergency this additional procedure was schedule a week prior to the date of service. Preauthorization should have been requested upon the decision for surgery and schedule on the procedure. There was ample time between the visit and the procedure so that preauthorization could have been requested. The determination that the procedure could wait seven days was, in itself determination that this was not emergency treatment."

The requestor contends that reimbursement is due because "[Claimant] was then seen for a post-op appointment on 7/25/2016 and after evaluation was scheduled for the medically emergent repair, (redacted). Again, prior-authorization was not obtained due to emergency case status."

The division refers to 28 Texas Administrative Code §134.600 and §133.2 to determine if the respondent's denial of payment was appropriate.

28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
(A)an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

28 Texas Administrative Code §133.2 (5) defines "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

Based upon the submitted documentation, the claimant (redacted). The division finds that the disputed services were not a result of a medical emergency as defined in 28 Texas Administrative Code §133.2 (5) , because there is no documentation of a sudden onset of a medical condition that required immediate treatment. In addition, the procedure was scheduled and performed one week from the last evaluation. The division concludes that the respondent's denial is supported. As a result reimbursement is not recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Elizabeth Pickle, RHIA	11/1/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.